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ABSTRACT

This report presents the findings and recommendations resulting from a study of the accreditation of 15 selected health education programs by a 13-member study commission. Section I of the report presents a summation of the basic issues and problems considered by the commission, including such issues as: (1) accountability, structure, financing, and expansion of accreditation, (2) research in accreditation, and (3) relationship of accreditation to licensure and certification. A detailed discussion of these issues is contained in a series of staff working papers available as VT 016 554 and VT 016 555 (Jan 73 RIE). Section II of the report outlines and discusses basic accreditation policies that pertain to post-secondary accreditation, including such aspects as: (1) purposes and functions of accreditation, (2) organization of accreditation, and (3) structure of accrediting agencies. Section III of the report presents the commission's conclusions and recommendations with respect to the functions, structure, operations, financing, and expansion of accreditation in the 15 health professional fields selected for study. (SB)

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Study of Accreditation of Selected Health Educational Programs

Commission Report

May, 1972 Washington, D.C.

This study was funded by The Commonwealth Fund.

ACCREDITATION is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study or their services.

CERTIFICATION is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

LICENSURE is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title or grants permission to institutions to perform specified functions.

REGISTRATION is the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency.

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Letter of Transmittal

AMERICAN MEDICAL ASSOCIATION
ASSOCIATION OF SCHOOLS OF ALLIED HEALTH PROFESSIONS
NATIONAL COMMISSION ON ACCREDITING

On behalf of the Commission appointed to study the accreditation of selected health educational programs I have the pleasure of transmitting this report to the three co-sponsoring organizations. The report comprises three sections.

Section One presents a summation of the basic issues and problems considered by the Commission in the course of its deliberations. A detailed discussion of these issues is contained in a series of staff working papers that were published and made publicly available in two volumes during the course of the study.

Volume I of the SASHEP *Staff Working Papers* was published in October 1971 and included the following: "Historical Introduction to Accreditation of Health Educational Programs," "Structure of Accreditation of Health Educational Programs," "Financing the Accreditation of Health Educational Programs," "Research in Accreditation of Health Educational Programs," "Expansion in Accreditation of Health Educational Programs," and a commissioned paper entitled "Accreditation of Postsecondary Education: Problems in Organization."

Published in February 1972, Volume II contains staff working papers entitled "Dilemmas of Accreditation of Health Educational Programs," "An Approach to Accreditation of Allied Health Education," "The Relationship of Accreditation to Voluntary Certification and State Licensure," and a second commissioned paper, "The Law's View of Professional Power: Courts and the Health Professional Associations."

In pursuing its assignment of studying and making recommendations regarding the future accreditation of a selected group of health educational programs, the Commission recognized early in its deliberations that it could not adequately review accreditation in the selected fields without reference to basic policies that would pertain to all of postsecondary accreditation. Since such basic policies had not previously been codified, it

was necessary for the Commission to prepare such a statement to provide a context within which its specific recommendations could be developed and established. This statement of Basic Policies for Accreditation is contained in Section Two of the Report.

Section Three presents the Commission's conclusions and recommendations with respect to the functions, structure, operations, financing, and expansion of accreditation in the fifteen health professional fields selected as the focus of the study. The fields selected for review were those in which accreditation was conducted on a collaborative basis under the aegis of the American Medical Association at the time SASHEP was begun. Although the number of fields subject to AMA accreditation has since been increased to eighteen, the conclusions and recommendations in Section Three are applied only to the fifteen allied health fields encompassed by the original SASHEP proposal.

There are a variety of ways in which the accreditation of the selected health educational programs could conceivably be improved and reorganized. After identifying a number of possible alternatives to the current system of accrediting these programs, the Commission in Section Three recommends the organizational pattern which it believes will most likely be capable of stimulating the necessary improvements in accreditation and of gaining the acceptance of the numerous groups and organizations that have a legitimate interest in the future accreditation of the selected health educational programs.

In pursuing its assignment, the Commission has enjoyed full independence of operation but at the same time has appreciated the support provided by its three co-sponsoring organizations. The Commission is also grateful to The Commonwealth Fund for its generous funding of the study and to the many individuals affiliated with professional accrediting and certifying agencies, educational institutions, hospitals, and government agencies for their assistance in providing the extensive information necessary for the conduct of SASHEP.

The members of the Commission wish also to record their appreciation to William K. Selden, director, Jerry W. Miller, assistant director, and Karen L. Grimm, research assistant, for the creative contributions that they have made to the study. Special attention should be called to the staff working papers on which the deliberations of the commission were largely based. In preparing these papers, Mr. Selden, Mr. Miller, and Mrs. Grimm held numerous discussions with representatives of the health professions and educators from educational institutions; they attended many meetings, and carefully analyzed the questionnaires completed by representatives of the health professions, educational institutions, hospitals, certifying agen-

cies, state licensure boards, and other governmental agencies. Their efforts have enhanced and facilitated the deliberations of the Commission.

The members of the Commission have enjoyed serving on this assignment. We have done so with a growing realization that the issues that we have identified are becoming increasingly important not merely to the accreditation of the selected health educational programs, but to the present and future members of the professions, to the institutions offering educational programs, and ultimately to all of society.

Underlying all our concerns is the realization that accreditation must be conducted with primary concern for the welfare of the public. We trust that as negotiations proceed for changes in accreditation the many individuals and organizations involved in the accrediting process will find this report to be a helpful guide in recognizing and implementing what will be in the best interest of the public welfare.

Arland F. Christ-Janer

ARLAND F. CHRIST-JANER
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SECTION ONE

Issues

Crucial to the effective functioning of any health delivery system is the availability of a sufficient quantity of competent health care personnel. In large measure, the quality of health care ultimately delivered is dependent upon the competence of those providing the care; and the competence of health care personnel is, in turn, largely determined by the quality of educational preparation for health service roles.

Traditionally, the primary responsibility for promoting and assuring professional education of high quality has been assumed by health professional organizations which, through their accrediting programs, set educational standards, monitor educational programs, and upgrade and improve educational preparation for entry into their respective fields. Adopting the pattern established by the medical profession, a number of health professions already have implemented their own accrediting programs and many more appear ready to follow in their footsteps.

Although accreditation has not been immune from public criticism, it has in general been valued and acknowledged as a socially useful means of identifying educational programs of acceptable quality, as well as of improving and upgrading the overall quality of education in health professional fields. At the present time, however, the accreditation for a number of health professions is not only being subjected to increasing public scrutiny and criticism from without, but is also beset by serious internal problems, pressures, and tensions that threaten to undermine the ability of the accrediting process adequately to serve the public welfare.

Well aware of these problems and their potential debilitating effect on the accrediting process, the Council on Medical Education of the American Medical Association, acting on the recommendation of its Advisory Committee on Education for the Allied Health Professions and Services, took the initiative in proposing that a cooperative study of health educational accreditation be undertaken. These efforts culminated in the Study of

Accreditation of Selected Health Educational Programs, commonly referred to as SASHEP. Sponsored by the Association of Schools of Allied Health Professions, the Council on Medical Education of the American Medical Association, and the National Commission on Accrediting, the study has been supported by a grant from The Commonwealth Fund.

From its inception, SASHEP has been conducted under the supervision and auspices of an independent Commission which bears ultimate responsibility for the recommendations contained in this report. The specific health professional fields selected by the Commission for most intensive study were those 15 for which accreditation was being conducted on a collaborative basis under the supervision of the American Medical Association at the time SASHEP was begun. (See Appendix B.) Although the study was mandated to focus its attention on the accreditation of these selected health professional fields, it was to "be conducted within the entire gamut of the health professions and services."

The overriding issue to be considered by the Commission was enunciated by Quigg Newton, president of The Commonwealth Fund, in advising the study's co-sponsors of the grant award.

> Professional education in these fields—which have become an increasingly vital component of the nation's health services—is being seriously encumbered by the costly maze of accreditation requirements and procedures imposed by the multiplicity of professional associations that characterize this important health manpower sector.
>
> The public interest requires that a means be found to promote collaboration between professional associations in allied health and educational institutions in these fields in an effort to create a new system of accreditation that will make possible a coherent, flexible, and rational approach to manpower development.

To aid the Study Commission in formulating its recommendations for this projected new system of accreditation, the SASHEP staff prepared a series of papers designed to elucidate the issues confronting the allied health accrediting sector, to delineate the problems responsible for its less than optimal functioning, and to pose possible alternatives by which the present system and process of accrediting the selected allied health educational programs might be improved. The material contained in these papers was based to a large extent on many personal interviews and discussions, as well as on information furnished through questionnaires by representatives of the various health professional organizations, educators, health care administrators, and government officials. The subjects of the papers, which were identified in the original proposal for the study, are:

I. Accountability of Accreditation

To whom and in what manner should the accrediting organizations be responsible: the professions, the schools and programs providing the education, the employers of the members of the professions, the users or recipients of the services of the professionals, the federal and state governments, and the general public?

II. Structure of Accreditation

What changes, if any, in the structure of the accrediting organizations and in their relationships to each other should be instituted in order to improve their accountability, their effectiveness, and their cooperation in planning and operation?

III. Financing of Accreditation

To what extent should the increasing costs of accreditation be met by revisions in the procedures generally pursued in accreditation and/or by seeking additional funds from the professions, the schools and programs being considered for accreditation, the state and federal governments, and gifts?

IV. Expansion of Accreditation

Should the expansion of accreditation to cover other types of educational programs in the health professions be controlled or restricted? If so, on what bases and by whom should such expansion be controlled? In what manner and on what basis should institutions operated for profit be considered for accreditation?

V. Research in Accreditation

What types of research in accreditation should be undertaken to simplify its procedures and to make its policies more effective in fulfilling the purposes which it is intended to serve, and how should it be sponsored?

VI. A Relationship of Accreditation to Licensure

How can accreditation and licensure, which are two distinct functions, be mutually modified in order that they may jointly and more adequately serve the purposes for which they are operated?

VI. B Relationship of Accreditation to Certification

How can accreditation and certification, which are distinct functions, be mutually modified in order that they may jointly and more adequately serve the purposes for which they are operated?

I. ACCOUNTABILITY OF ACCREDITATION

Health professional bodies have traditionally been accorded the primary responsibility for setting standards for individual entry into health profes-

sional fields. One method by which professional organizations discharge these responsibilities is through accreditation of specialized programs of study.

Until recently such accreditation has generally been considered to be the unique responsibility and province of the various health professions themselves. But no longer do such assumptions prevail. Current forces are prompting intensive reexamination of the health professions' authority to serve as the sole arbiters of educational standards, as well as the only participants in the other mechanisms by which health professionals have traditionally been screened and policed.

One important factor that is forcing a reevaluation of the health professional's position in relation to society is the tendency—and necessity—for professional organizations to give increased emphasis to the economic and social welfare of their members. This development serves to accentuate the conflict of interest inherent in the professional association's bifurcated responsibility to its members on the one hand and to society-at-large on the other.

Concurrent with this development is the altered status and reputation of the professional. No longer is it uniformly believed that the acts of professionals are totally beyond the comprehension of laymen. Just as it is now realized that accreditation depends not only on technical expertise but also involves issues of broad social import, so also is it widely acknowledged that understanding of the accrediting process and its implications is not limited to the health professions directly involved.

Furthermore, accreditation that is controlled by health professional bodies has come to be heavily relied upon by many different segments of society, including government agencies that utilize accreditation as an initial criterion both for the disbursement of public funds and for individual licensure. With the increasing visibility of health as a political issue of considerable magnitude, and the concomitant increasing government support of health education and of health care, it is to be expected that the public will demand greater assurance that the health professions do indeed exercise their standard-setting roles in the best interests of society.

These factors, among others, argue that the accrediting process must be held accountable not merely to the health professions, but to a much broader constituency. This broader constituency includes in varying ways the educational institutions that offer programs of study in health professional fields, the potential employers of health professionals, the federal and state governments, students, and ultimately the public-at-large.

II. STRUCTURE OF ACCREDITATION

A. Accountability

The current structure of accreditation of specialized fields of study is geared to an anachronistic perception of accreditation as a private activity, accountable only to the professional organizations by which it is sponsored, conducted, and controlled. For example, few accrediting agencies currently include any lay members on their boards. Nor do they even include persons from a spectrum of other related professions. Moreover, provisions for guaranteeing minimal due process for aggrieved parties have been more the exception than the rule. As currently structured and conducted, it is clear that accreditation in most health fields gives no more than token recognition to its substantial public trust functions and responsibilities.

B. Barriers to Effectiveness

Duplication. In the past, any health professional organization that wished to initiate an accrediting program was free to do so even when there were no discernible benefits to be realized by society in such expansion. In 1949, the National Commission on Accrediting was established by a consortium of colleges and universities attempting to control the proliferation of specialized accrediting agencies. At the present time, both the National Commission on Accrediting and the U. S. Commissioner of Education exert some degree of control over unnecessary expansion in the accrediting field through their separate authorities to recognize accrediting agencies. However, as evidenced by the number of accrediting groups that continue to operate without either NCA or Office of Education recognition, the efforts of these two agencies have not been totally successful in curbing what many consider to be the unwarranted expansion of accreditation to additional fields of study.

One unfortunate result of the insufficiently governed expansion of accreditation has been the duplication of agencies accrediting programs in the same health field. Practical nursing offers one example of this occurrence; the medical laboratory fields are another. Wasted resources, jurisdictional disputes, unhealthy competition, and confusion have emerged as some of the unfortunate byproducts of this state of affairs. There seems to be little doubt that the overall effectiveness and efficiency of health educational accreditation has been hampered by the duplication of accrediting programs in selected health fields.

Jurisdictional Tensions. As new specialized occupations have been spun out of existing professions, jurisdictional issues between professions have

not only grown in importance but have also in many cases led to competitive struggles among groups of health professionals. In the process, control over educational standards and accreditation has frequently become one pawn in the play for power since the potential for one health profession to exert economic, as well as professional, control over another through the regulation of educational standards is clearly present.

Nowhere are jurisdictional disputes in accreditation more evident, nor their cumulative effect more debilitating, than in the accreditation of the selected allied health educational programs. Seeking to provide a vital service that no other organization was in a position to provide, the American Medical Association initially assumed the responsibility for acting as the primary coordinating body for the accreditation of allied health programs and has, in recent years, committed substantial financial and administrative resources to its allied health accrediting activities. Currently the accreditation of allied health programs is, in theory, conducted on a collaborative basis with both the AMA and selected allied health professional organizations and medical societies participating in the establishment of accrediting standards and the accreditation of educational programs. By applying to accreditation the widely accepted tenet that vests ultimate responsibility for patient care in the physician, the American Medical Association continues to exercise final authority over both the adoption of accrediting essentials and the accreditation of individual allied health educational programs.

This collaborative system, however, is somewhat different in practice than in theory. Physician participation in both the drafting of accrediting essentials and the accreditation of individual allied health programs has, in many cases, been minimal. The approval of educational standards and progrms has to date been largely a pro forma exercise on the part of the AMA. As a result, representatives of many of the allied health professional organizations currently collaborating with the AMA maintain that the medical profession controls too much and at the same time that it contributes too little.

Compounding the strains between the AMA on the one hand and several of the collaborating allied health professional associations on the other, are the jurisdictional and power struggles within some of the joint review bodies that cooperate with the AMA in the accreditation of allied health educational programs. In five of the selected health fields, the AMA collaborates with only one allied health organization; in the remaining fields, the AMA collaborates with and operates through joint agencies that are typically composed of physicians appointed by medical specialty societies, and allied health professionals appointed by their respective professional

associations. (See Appendix B.) From all indications, it appears that the effectiveness and performance of most of these joint agencies is being undermined by substantial interprofessional conflicts, tensions, and rivalries. Combined with the less than cordial relationships existing between several of the allied health collaborating organizations and the AMA, it is to be expected that these intra-group tensions will exacerbate already existing administrative problems, and further jeopardize the ability of accreditation to meet adequately its social responsibilities.

Under the collaborative accrediting arrangement, the American Medical Association is responsible for supervising and coordinating accreditation in the fields under its jurisdiction. However, it would appear that the AMA has, at least to date, been either unable or unwilling to exercise adequate control over the accrediting programs operating under its aegis. In some instances entire accrediting programs have either not been adequately initiated or have been allowed to drift into disrepute. In other situations, the AMA has not enforced some policies, which were endorsed by the Council on Medical Education, against the determined wills of some of the groups operating under its supervision and authority.

Despite valiant attempts that have been made in recent years, it is clear that the accrediting system for allied health education is still functioning at less than an optimal level. The cause for this condition can be attributed, at least in part, to some inherent deficiencies in the administrative organization and application of accreditation to the selected allied health programs.

The success of accreditation is heavily dependent upon the effective functioning of a critical educational mass which includes: (1) a body of professional expertise composed of individuals who devote a substantial portion of their time to teaching, and interact with each other to provide frequent checks upon professional performance, and (2) an educational organization and a set of procedures that can exercise adequate control over the quality of educational programs and provide reliable assurances regarding the integrity of the credentials awarded to individuals. Many of the programs currently accredited in the selected allied health fields meet neither of these criteria.

More than eighty percent of the AMA-accredited programs in allied health education are located in hospitals and laboratories, which tend to have both small enrollments and small teaching staffs. Consequently, there is often insufficient organizational provision for ensuring program quality, continuity, stability, or direction. Although affiliations with academic institutions could theoretically provide this assurance, the current approach to allied health accreditation places major emphasis on the accreditation of

the clinical portion of the educational program, even though the academic institution awards the degree or other credential and bears ultimate responsibility for its integrity.

Furthermore, the logistical problems of accrediting small, isolated clinical programs are substantial. The sheer number of such programs applying for accreditation creates an almost unmanageable workload for some of the accrediting review groups, which are manned primarily by volunteers. As a result of their overwhelming workloads, review bodies have in some instances been able to give little more than superficial evaluation to the programs of study subject to their review; in some instances the established interval between periodic revisitations has even had to be extended.

In addition to the basic question concerning the feasibility and advisability of accrediting clinical training programs as separate entities, the administrative machinery for accrediting the selected allied health programs can be questioned on at least two counts.

First, the current collaborative arrangement for decision-making appears to be both cumbersome to the accrediting bodies and confusing to educational institutions. Moreover, in cases where multiple interests are involved, the system has the potential for producing a serious impasse, especially in the establishment of basic accrediting policies and the approval or revision of essentials.

Second, the lack of a detailed working agreement between the AMA, the joint review bodies, and the collaborating organizations has encouraged some confusion, particularly concerning AMA staff duties and responsibilities. The AMA's present role of supervisor carries with it the responsibility for promoting a certain beneficial degree of uniformity among the review bodies operating under its jurisdiction. In the past several years there has been definite improvement in this respect. However, the lack of a definitive agreement on standard operating procedures and policies to be applied across-the-board to all collaborating agencies has delayed the maximum realization of this goal.

C. The Need for Cooperation

The collaborative approach for accrediting allied health education was originally conceived as a process by which effective cooperation and coordination in the accreditation of allied health programs could be promoted and ensured. The current structure suggests that attainment of this laudable goal has not only been prevented by a kind of professional nationalism, but has also, until very recently, been simply ignored and overlooked in the administration of accrediting allied health educational programs.

There continues to be a separate review committee for each allied health professional field. Each committee conducts its own site visits independently of the other allied health review bodies. Each committee continues to take separate actions on each program before forwarding its recommendations to the Council on Medical Education through the Advisory Committee on Education for the Allied Health Professions and Services. The Advisory Committee has neither the power nor the authority, under the current structure, to promote the necessary coordination among the review bodies. Its many and various accomplishments to date have been attained largely as a result of diplomatic persuasion; but much more must now be accomplished, and the present structure merely frustrates the fullest possible attainment of this objective.

Conducting a separate accreditation program for each occupational specialty tends to fragment allied health educational efforts, especially for the junior and four year colleges and universities which are rapidly assuming major responsibility for the training of allied health personnel. Moreover, it is likely that such fragmentation will merely encourage the perpetuation of even more narrowly oriented educational programs whose graduates will consequently find it increasingly difficult to achieve sufficient upward and lateral mobility within the health care system. At the same time that the "medical team" is being hailed as the health care delivery unit of the future, and core courses are advanced as one of the most efficient and effective means of preparing health professionals for their future service roles, the accreditation of allied health educational programs continues to be conducted on an inefficient, fragmented basis.

III. FINANCING OF ACCREDITATION

The problem of financing health educational accreditation is intimately related to the problems and issues endemic in the current structure and method of accrediting allied health educational programs. Traditionally, health educational accrediting programs have been financed primarily by health professional organizations, which, by virtue of their substantial financial contributions to the accrediting programs, have exerted virtually complete control over the accrediting process. However, mounting financial pressures on health accrediting agencies are now prompting a reevaluation of the financing methods followed in the past with the result that many agencies are turning with increasing frequency to educational institutions and programs of study to help them finance their accrediting programs.

Nowhere are the problems of adequate financing more vexing than in

the accreditation of the selected allied health educational programs. Rapid expansion in the numbers of programs subject to accreditation, coupled with rapidly rising costs, render adequate financing a problem of major importance to many of the groups involved in accrediting the selected health educational programs. Like many of the other health accrediting agencies, some of the allied health accrediting groups have already turned to educational institutions and programs of study for financial assistance, and others plan to do so in the near future. In fact, if the trends of the past obtain in the future, it would appear that the long-term viability of accreditation in the selected allied health fields will, in large part, be dependent on the willingness of educational institutions to support the accrediting process.

The prognosis for continued long-term assistance from the education community is somewhat questionable. Educators complain of duplicative, unnecessary paper work, high indirect costs, and disruptive site visits necessitated by the uncoordinated nature of accreditation in the health fields. While not necessarily averse to providing support to the accrediting process through the direct payment of fees, educators will assuredly demand a voice in the accrediting process commensurate with their monetary contributions.

Accrediting agencies may anticipate little support for their operating expenses from foundations, and government funding raises questions of control. Therefore, the only two readily available and desirable sources of funds for accrediting allied health educational programs are health professional associations and the institutions offering allied health programs. Since monetary support is intimately tied to control and influence, a judicious balance between these sources of funding is required. However, if the education community is to be expected to provide additional assistance to accrediting agencies, it is likely that its justifiable grievances will first have to be considered—and rectified—by the accrediting sector.

IV. EXPANSION OF ACCREDITATION

Promoted by the fast pace of technological advance and the accompanying need for specialization, new health professions are emerging with increasing frequency on the health manpower horizon. If the patterns of the past hold true for the future, these newly emerging professions will attempt to embark on their own accrediting programs. As a result, it can be expected that further strains and misunderstandings will develop, additional professional jurisdictions will be established, and monetary and personnel

resources will be wastefully expended in defense of these jurisdictional interests.

As health occupations seeking to initiate accrediting programs proliferate, accreditation is also expanding vertically as existing agencies extend their accrediting activities to different levels of study and preparation. Increasing numbers of educational programs located in traditional learning institutions, combined with the potential extension of accreditation to proprietary and military programs, lend additional impetus to the pressures for expansion already confronting the health educational accrediting sector.

It is apparent that the future viability of allied health educational accreditation is dependent upon the existence and successful performance of an organization having both the authority and the respect to control the inappropriate expansion of accreditation to additional fields; to integrate new accrediting programs into an existing organizational framework; and to ensure effective cooperation, coordination, and liaison among all groups having a direct interest in the accreditation of allied health programs.

V. RESEARCH IN ACCREDITATION

Of the many criticisms leveled at accreditation, none are more difficult to refute than those aimed at the validity of accrediting procedures and standards. Criteria for accreditation are still adopted by most accrediting agencies solely on the basis of subjective judgments even though the state of the art would permit the use of more scientific techniques of evaluation.

To date, little research in regard to either the criteria or procedures of accreditation has been performed. The relative absence of research in this important field has been the result of several factors, including: (1) the lack of sufficient financing, (2) the tendency of many accrediting agencies to maintain the status quo, and (3) the lack of a critical organizational mass that could sponsor pertinent research and upon which accrediting agencies could rely for objective analysis of their standards and procedures.

Whatever the specific reasons for the past and current lack of accreditation-related research and validation, it is improbable that the public will continue to accept a system based only on subjective individual judgments. In view of the dynamic changes occurring in educational theory and practice—changes signaled by the emergence of free universities, credit-by-examination programs, universities without walls, and other alternatives to conventional educational programs—it is not only likely but virtually inevitable that the traditional criteria utilized by accrediting agencies to evaluate educational programs will be subjected to increasing scrutiny and

criticism. The validity of accreditation will not be able to stand indefinitely on the sole basis of individual presumptions of supposed worth. Only if objective evaluative techniques replace—or at least supplement—subjective evaluations will accreditation be able to maintain its credibility.

Despite some inherent difficulties, research designed to validate the development, substance, and application of accrediting criteria is basic to the future viability of accreditation in all fields. Any future system of allied health accreditation must be structured to overcome organizational, financial, and attitudinal barriers to needed research in these areas. Acceptance of research as a high-priority concern of all agencies responsible for accreditation in the health fields should be promoted; and adequate financial resources should be made available to support the necessary research in allied health educational accreditation.

VI. THE RELATIONSHIP OF ACCREDITATION TO LICENSURE AND CERTIFICATION

A. Licensure

The establishment of educational criteria for state licensure is widely regarded as one of the prime functions of specialized accreditation. The licensing boards for most health professions use the lists of institutions accredited by national, specialized accrediting agencies to evaluate the educational preparation of prospective licensees. Oftentimes, statutes specify graduation from a professionally accredited school as prerequisite for licensure. In other cases, rules or routine practices of licensure boards require graduation from a nationally accredited program of study. In either event, state licensure—and hence the legal authority to practice—is often limited to those who have successfully completed professionally accredited programs of study.

The social desirability of using accreditation as a criterion for state licensure has as yet not been authoritatively analyzed. On the positive side, proponents point out that the existence of national accreditation has: (1) relieved licensing boards of the expense and responsibility of mounting their own full-scale accrediting programs; (2) facilitated the mobility of health personnel across state lines; and (3) created uniform national standards for selected categories of health personnel.

Those who question the desirability of limiting eligibility for licensure to individuals who have graduated from accredited programs suggest that the requirement may have the effect of barring otherwise qualified individuals from practice. They also question the need for *both* accreditation *and*

licensing examinations to judge the competence of prospective health professionals and to guard the public against unqualified practitioners. Whether accreditation should continue to be a criterion for state licensure raises an issue of substantial social importance.

B. Certification

Unlike licensure, which is a government-sponsored process designed to exclude the unqualified from practice, certification, like accreditation, is a voluntary process sponsored by the health professional sector. Certification programs are usually sponsored by the same national health professional associations that conduct counterpart accrediting programs. Whereas accreditation speaks to educational standards and certification to the competency of individual practitioners, both are ostensibly based upon a common core of expertise and knowledge that the national professional association has identified as critical to effective and competent performance on the part of the individual practitioner. As a result, accreditation and certification are most often seen by the professions as complementary screening mechanisms, collectively designed to identify qualified personnel and to ensure the public of high quality medical care. Both structurally and functionally, the processes of accreditation and certification are linked by strong operational and organizational ties, and are welded together by the common denominator of professional sponsorship and control.

Flowing from the conception of accreditation and certification as complementary screening mechanisms is the common practice of restricting eligibility for certification to those who have graduated from accredited programs. Many certifying agencies will permit only those who have been graduated from accredited programs to take the required qualifying examinations. While this practice may be both socially necessary and desirable, it is also true that, to those who have not graduated from an accredited program of study, the prerequisite of accredited educational preparation may be seen as an unnecessarily restrictive device, attuned more to the validation of educational training than to the assessment of basic competence to serve. It is anticipated, however, that the continued development and implementation of equivalency and proficiency examinations will render the health manpower credentialing system more responsive to the needs of individuals trained in non-traditional programs and to the demands of society for more qualified health care personnel.

Certification is widely utilized by many segments of society in identifying those who, on the basis of professional judgment, are judged competent to render health care of high quality. Because of its widespread acceptance,

certification has the power to exert considerable influence over both the quality and utilization of health care personnel. Thus, the basic premises upon which certification operates merit serious consideration.

C. Accreditation, Certification, and Licensure

Considered together, accreditation, certification, and licensure constitute a series of screening mechanisms designed to identify personnel thought to be competent and qualified to render medical care to the public. All three mechanisms were originally introduced by the medical profession at different points in time in response to distinct needs and objectives of that profession. Not unnaturally, other health professions subsequently adopted the same screening mechanisms evolved by medicine—but ofttimes, it would appear, without sufficient critical attention to their historical antecedents or to the functions these mechanisms are individually and collectively capable of serving. As a result, there is now considerable confusion in the minds of both the professions and the public regarding the proper roles of accreditation, certification, and licensure, and their interrelationships to one another.

Some maintain that certification and licensing boards should demand graduation from an accredited program of study as a precondition for both certification and licensure; others claim that this requirement unduly bars from the health manpower pool well qualified individuals who happen to have received their training in non-accredited or non-traditional settings. Some believe that the combination of accreditation and certification or licensure is unnecessarily duplicative; others maintain that the public interest demands such a dual or triple system for checking the competency of health professionals. Some professions mistakenly attempt to impose certification as a functional alternative to state licensure; others use certification as a means to provide peer and public recognition for those who have attained expertise greater than the minimum required to practice.

Accreditation, certification, and licensure can no longer be considered as isolated processes, self-sufficient and self-accountable. Through time, all have become inextricably welded into one credentialing system, whose collective raison d'etre is the identification of qualified health personnel to staff the health care system. It is obvious that any future system of specialized health accreditation will have to take into account, on a regular on-going basis, its role as one of several manpower credentialing agents. It is equally certain that this responsibility cannot and will not be adequately discharged without the additional critical data needed to answer

the myriad unanswered questions about the dynamic interrelationships among accreditation, certification, and licensure.

SASHEP was mandated to focus its attention upon only one of the three credentialing mechanisms—accreditation. Concurrent with the conduct of the Study of Accreditation of Selected Health Educational Programs, other organizations have expressed substantial interest in launching separate studies to analyze certification and licensure. The American Medical Association and the American Hospital Association have initiated joint efforts to study state licensure. In September, 1971, the National Institutes of Health, in cooperation with the Association of Schools of Allied Health Professions, sponsored an invitational conference on certification to explore the feasibility of conducting a comprehensive study on professional certification. The recent *Report on Licensure and Related Health Personnel Credentialing*, mandated by Congress, recommended that "the Assistant Secretary for Health and Scientific Affairs undertake or initiate the development of a report exploring the feasibility of establishing a national system of certification for those categories of health personnel for which such certification would be appropriate." Initial steps toward the implementation of this recommendation have been taken.

Increasing public awareness of the intricate interrelationships among accreditation, certification, and licensure coupled with growing public concern over their combined impact on both the quality and availability of health personnel make it imperative that additional research be conducted to: (1) clarify and analyze the existing interrelationships among accreditation, certification, and licensure with a view toward determining if they are duplicative, complementary, or conflicting methods of identifying qualified health personnel; (2) determine what combination of these or other types of regulatory mechanisms are needed to protect the health of the public; and (3) recommend the changes necessary to adapt accreditation, certification, and licensure to the functions that they, individually and collectively, should be expected to serve both in the present and in the foreseeable future.

SUMMARY

Problems of accountability, structural deficiencies, pressures for expansion and increased levels of financial support, and the absence of objective, scientific validation of accrediting standards and procedures have converged to undermine the potential effectiveness, social value, and public credibility of accreditation in many health professional fields. Heavy social

reliance on accreditation as a manpower credentialing mechanism has tended to focus increased public attention on the shortcomings of accreditation and to provide additional impetus for early resolution of the problems, tensions, and issues currently jeopardizing the social usefulness of the accrediting process. The original proposal for this study included the following declaration:

> The pressures and issues in the accreditation of programs for the health professions have been mounting, especially during recent years. If they are not recognized and resolved on a cooperative basis, a situation is likely to develop in which it may be impossible to reach any amicable resolution. It is timely, therefore, that a cooperative study of these issues be undertaken in such a manner that the results of the study will lead to action and implementation.

Throughout the course of the study, SASHEP has been conducted on the assumption that its investigations, observations, and recommendations would in fact lead to constructive action and implementation of needed revisions in the accreditation of the selected health educational programs. It is to this ultimate goal that the recommendations contained in Sections Two and Three of this Commission Report are specifically addressed.

SECTION TWO

Basic Policies for Accreditation

From its inception accreditation has been the subject of conflicting opinions as to its value for educational institutions, for hospitals, for their programs of study, for society, and even for the organizations that sponsor accrediting activities. Its benefits are hard to prove, and its deficiencies are difficult to document.

It is frequently noted that accreditation has served as an effective catalyst for improvement and general raising of standards in institutions and their programs of study. As a result of its influence, increased financial support has been provided to institutions. Both educators and professional practitioners have been stimulated to consider educational issues and related factors from a broader point of view. Prospective students and employers have been provided with reasonable assurance of the quality of institutions, and institutions have also been aided by accreditation with respect to admission of students. Foundation officials and other donors of funds have been guided in their decisions by the results of accreditation, and some institutions have been protected from harmful pressures and influences by either the threat of or by actual disaccreditation. Basic to all these benefits of accreditation is its main function: the evaluation and recognition of a program of study or an institution that has met certain predetermined qualifications or standards.

Concurrent with these words of praise there are frequent accusations directed at the accrediting process. Claims have been made and are continuing to be made that the standards for accreditation are frequently irrelevant to good education; that programs of study and their administrations are forced to conform to the dictates of narrowly based professional and technical groups; that experimentation and innovation are unduly hindered and mediocrity of education enhanced; that the costs and expenses related to accreditation are excessive and disproportionate to the results; and that educators and administrators are unnecessarily distracted from

their primary and more important responsibilities by the demands of the proliferating and uncoordinated accrediting agencies.

Despite the controversies that have ensued over its worth, the role of accreditation has continued to expand, apparently attesting to its social value. Originally established by the private sector to attain more limited objectives, accreditation now fills a broader need in society. If it were not sponsored and conducted by independent organizations, a process of inspection and possibly some form of control would have to be instituted by government, probably on a national basis.

To enhance and improve the effectiveness of accreditation as it is conducted by the private sector, the Commission for the Study of Accreditation of Selected Health Educational Programs (SASHEP) has adopted the following statement of basic principles with specific concern for their applicability to the accreditation of the allied health educational programs. The Commission considered it necessary to develop such a statement prior to the adoption of the recommendations contained in Section Three of this Report. However, the Commission hopes that these basic principles will have such widespread relevance that they will be considered and accepted by all who share any responsibility for accreditation of post secondary education.

I. PURPOSES AND FUNCTIONS OF ACCREDITATION

I. A

Since the primary purpose of accreditation is to serve the needs of society by identifying those institutions or programs of study that meet acceptable standards of educational quality, accreditation should be sponsored and conducted only when there is a demonstrable social need.

Accreditation meets an essential need in our society created by the fact that our federal system of government with its balance of powers did not make provision for a national system of education, and the fact that the several states, which have legal jurisdiction over education, exercise these responsibilities in an inconsistent and uneven manner. The need for the establishment and maintenance of acceptable standards of educational quality on a national level for both private and public education has been met by accreditation conducted by non-governmental agencies and organizations. This social need should continue to serve as the primary principle on which accreditation is based.

In defining demonstrable social needs, there are various means by which

these are identified in our society. The will of the people is identified in one way through the actions of their federal, state, and local governments. It is also expressed through a multitude of non-governmental channels, such as those identified in this statement of basic policies for accreditation. (See IV.)

In considering whether there is a social need for a program of specialized accreditation, attention should be given to the requirements for public protection from incompetent practitioners. Furthermore, account should be taken of other mechanisms of control that may be or could be operated for each field of study for which accreditation is being considered. These other mechanisms include, but are not limited to, certification, licensure, and registration. (See IV. B. 5.) The most appropriate and efficient means of identifying quality in educational programs and in professional personnel should be employed to meet the needs of society.

I. B

In serving the needs of society accreditation should be soundly constructed and operated so that consideration is given to the interests of institutions, to their programs of study, to members of the professions, and others who have legitimate concerns with the educational process, as well as to the concerns and responsibilities of the government.

Even though the needs of society must be considered uppermost, if only the interests of society governed accreditation, the process might inadvertently overlook the legitimate special needs of institutions and individuals. The needs of the institutions and their programs of study, of the professions and their members, and of other sectors of society must be recognized and reconciled with overall social needs and objectives. Where there is a conflict, societal interests must prevail. (See II. C, III. A, and V. A.)

I. C

The uses of the lists of accredited institutions, including the uses by the federal government and the various state governments, should be recognized in the conduct of accreditation; however, these uses should never be permitted to subvert accreditation from its intended purposes and the functions which it is capable of serving.

The employment of accreditation by the federal government as one of a number of screening devices in the selection of institutions for grants of funds, as is currently followed in a number of different funding programs, has provided the government with a means of identifying potential recipients of federal funds at little effort and cost to the government. However,

accreditation was not created to serve this purpose, nor was it created to effect social reforms. If the federal government continues to rely on the lists of accredited institutions, as it presently does—and this is a decision that must be made through the processes of government—it should do so in such manner that government, federal or state, does not attempt to force the accrediting agencies to conform to what government officials unilaterally consider should be their posture.

I. D

Accreditation should be designed and conducted in such manner that it serves as a guiding influence in the development, improvement, and operation of institutions and their programs of study.

In accreditation there is a sharp line to be drawn between prescription—thou shall and thou shall not—on the one side, and complete freedom, in which anything is acceptable, on the other. This line must have form and substance at the same time that it has elasticity both to accommodate the singular and unusual in matters of quality, and to provide a propellant for innovation and further improvement where needed.

II. OPERATIONS OF ACCREDITATION

II. A

Policies, procedures, and standards of accreditation should be established and applied on a national and uniform basis.

Appropriate differences in the administration of accreditation may be necessary and desirable because the United States is a large nation in which variations in culture and social patterns do exist. However, in view of the fact that accreditation of institutions and of their programs of study is equally important throughout the country, these proper differences in the administration of accreditation should not be permitted to encourage discriminatory or unfair treatment. To guard against the intrusion of inequality or unfairness into the accrediting process, its policies, procedures, and standards should be adopted and applied on a uniform basis.

II. B

The policies, procedures, and techniques of all accrediting agencies and organizations should be adopted only after thorough analysis and validation, and should be subjected to continual analysis and review to

ensure that they are appropriate, consistent, and sound for the purposes for which they are employed.

The principles and techniques of measurement have been refined to such an extent that they offer increasing promise of greater assistance not only to improve the evaluation of institutions and their programs of study but also to simplify the accrediting process. Continual analysis should be made of current and possible future policies and procedures employing principles and techniques of measurement in such analyses. Such analyses or research may be of two kinds. One would emphasize improvements in and validation of the techniques of accreditation; the other would analyze the assessments of the inputs and the outputs of institutions and their programs of study and the application of these assessments to the process of accreditation. (See IV. B. 5 and V. C. 4.)

II. C

Accrediting agencies should make provisions on both their visiting committees and their review committees for persons with various competencies, including those with intimate knowledge of the educational programs preparing individuals for the respective professional fields, as well as those directly aware of the concerns of students and prospective employers.

The purpose of education is to assist students to prepare themselves for lives of usefulness. Individuals vary widely in personal attributes and desires, and employment opportunities and requirements continue to be in a state of constant change. Furthermore, education is offered successfully in many different types of institutions, and accreditation should not be dominated or controlled by individuals who represent any one type of institution or field of study. To give adequate recognition to these and other factors the accrediting agencies should ensure that the composition of their visiting and review committees represents varied, relevant, and appropriate points of view and experience. (See I. B, III. A, and V. A.)

II. D

The policies, practices, and standards of accrediting agencies should recognize the interdependence of elements constituting an educational institution, and, therefore, should give adequate attention to the total institution when considering one or more of its programs of study.

To help counteract the tendency of each accrediting agency to consider its functions to be separate from the functions of other accrediting agencies

and from the functions of other organizations concerned with the education and identification of qualified professional personnel, and to give recognition to the fact that educational institutions are not merely service agencies offering a series of distinct educational programs, all accreditation should be conducted with adequate recognition of the total institution being subjected to evaluation.

II. E

Accreditation should be an inclusive system, in which the right to be evaluated should not be denied to an institution or a program of study solely because of type of control or type of financial support.

To meet the needs of society, accreditation is expected to identify those institutions or their programs of study that have been evaluated and considered to be of reasonable quality. Reasonable quality is not limited to institutions, for example, that are governed by independent boards of control or financed on a not-for-profit basis. To identify all institutions offering reasonably good education, accreditation must be operated on a nonexclusive basis; otherwise, society is not provided the extent of services and protection that it has been led to expect, and needless proliferation of separate accrediting agencies is thereby encouraged.

II. F

All accreditation should be conducted in an equitable and fair manner, and consistent with the right of appeal and due process.

To fulfill this principle, various procedures should be followed by all accrediting agencies and organizations. These include:

(1) Current information with respect to the policies, practices, procedures, and standards, as well as the actions regarding the accredited status of institutions and/or their programs of study, should be made publicly available;

(2) All proceedings of accrediting agencies should be conducted so that affected institutions, organizations, and persons are provided opportunities to express their points of view before final decisions are reached;

(3) The formulation of standards and the administration of accreditation should be conducted in such manner that noninstitutional and nonprofessional interests have opportunities to participate in the process with the institutional and professional interests; and

(4) Mechanisms should be established by which appeals will be considered by impartial bodies, different in composition from those making the original accrediting decisions.

II. G

Accreditation should be conducted with a minimum of effort, time, and financial cost, consistent with attainment of the purposes that accreditation is intended to serve.

Each accrediting agency should be expected to make frequent analyses of its personnel and financial demands with respect to the cost effectiveness of the organization's operations, and be prepared to submit these analyses to the national monitoring body for review. (See IV. B. 2.) In these analyses attention should be given to the continued relevance to the purposes of accreditation of the activities of the individual accrediting organizations.

III. ORGANIZATION OF ACCREDITATION

To fulfill the purposes and functions of accreditation, agencies and organizations are required to assume different responsibilities. Although these organizations will possess different characteristics, depending on the responsibilities that they are expected to fulfill, the following characteristics should be common to all.

III. A

All accrediting agencies and organizations should provide adequately in the process of accreditation for involvement of individuals concerned primarily for the public welfare, as well as for involvement of faculty and other educators, members of the respective professions, members of related professions, students, and employers.

Accreditation involves issues of broad social importance and, therefore, should be subject to the judgment primarily of individuals who will not gain personally or directly from decisions of basic policy. In addition, such diverse participation would tend to counteract the insularity which is a potential, if not an actual weakness in the current structures of accrediting organizations.

The proportion of such individuals involved in the processes of accreditation should be expected to vary directly in relation to the breadth and substance of the issues to be resolved and the policies to be established. At the level of application of policies, those with professional knowledge and technical expertise would normally be expected to predominate. At the level of policy making, many diverse elements could and should participate. (See II. C and V. A.)

III. B

Accreditation should be conducted by such agencies, in such manner, and with such procedures and standards that there is adequate protection against the eventuality that decisions could be influenced by the possibilities of financial or professional advantage.

As accreditation has increased in importance to society, it has become correspondingly important that decisions regarding the policies, practices, and standards of accreditation not be subject to approval or review by bodies or organizations comprised solely of institutions or individuals whose economic, political, or social welfare is concurrently being represented by these bodies or organizations. Otherwise, the acceptance of and confidence in accreditation by the public will be placed in jeopardy, and the future values of accreditation will likely be eroded.

III. C

All accrediting agencies should be organized in such manner as to enable them to conduct their operations in the most efficient manner, including the coordination or consolidation of activities, for the purpose of eliminating proliferation and duplication and of assuring consistency in the development of standards and in the application of standards to institutions and programs of study.

To encourage joint educational planning and to avoid confusion, duplication, proliferation, and unnecessary financial burdens on society, accrediting agencies should be expected to coordinate, and, in some cases, consolidate their activities. Although the individual interests of the various professions and the various types of institutions offering educational programs must be recognized, they do not possess the inherent right to operate independently nor necessarily the competence to make unilateral decisions on broad policy issues related to accreditation. (See IV. B. 4 and V. B.)

III. D

All boards, agencies, and organizations involved in accreditation should review the structure of their respective organizations with periodic regularity in order that appropriate revisions can be effected to meet changing needs, and reports of these reviews should be made to the national monitoring body for accreditation.

Most accrediting agencies include, among their essentials or standards for accreditation, reference to the expectation that self-evaluation and self-improvement will be a goal of each institution and program of study. The

same principle applies to all accrediting agencies and organizations. Adaptability and flexibility in their organizations and structures must be constant features of the accrediting agencies in order that they not be a stultifying influence on education and educational change. (See IV. B. 2.)

III. E

All accrediting agencies and organizations should be incorporated not for profit, and their financial operations should be subject to annual audit by a certified public accountant whose reports should be made publicly available.

Consistent with their primary responsibility to society, all accrediting agencies and organizations should submit their financial operations to review and the reports of such audits should be made available for public scrutiny.

IV. MONITORING OF ACCREDITATION

In the past, accreditation has grown and expanded with little coordinated planning and supervision. As a consequence, there are many overlapping and duplicative efforts. These could and should be markedly reduced. In many instances, these overlapping and duplicative efforts could be eliminated by an effective means of monitoring all accrediting activities, especially those conducted for postsecondary institutions and programs of study. Furthermore, accreditation is now intertwined so intimately with many issues of broad public policy that society can ill afford to permit this activity to be continually conducted in a diffuse, ever-expanding, and unsynchronized manner.

(Although SASHEP was not assigned responsibilities to make recommendations with regard to a national monitoring and coordinating body for accreditation, the Commission recognized that its recommendations regarding the accreditation of selected health educational programs would require a frame of reference which would include such a body. Therefore, the following recommendations are included in this statement of basic policies for accreditation.)

IV. A

Accreditation should be coordinated, monitored and supervised by a national, independent body, governed by a policy board composed primarily of individuals who represent the public interest and, in addition,

individuals who may be directly associated with institutions, their programs of study, the professions, and the civil government.

In order to assure that the decisions of this policy board shall be made within the context of the welfare of society, and in order to reduce the possibilities of conflicts of interest, the majority of the membership should be composed of individuals who are unlikely to gain personally by the decisions of the board.

(The Commission assumes that, to be effective, this national, independent monitoring body would be expected to fulfill the following responsibilities.)

IV. B

The national, independent body responsible for monitoring accreditation would be empowered, among other things, to:

1. *establish policies, or criteria for recognition, to which all accrediting agencies or organizations shall adhere;*

2. *review periodically, for purposes of approval or disapproval, the policies, procedures, and practices of all accrediting agencies and organizations (see III, D);*

3. *approve or disapprove the initiation or extension of accreditation to include additional programs of study or new types of institutions;*

4. *require the coordination or consolidation of accrediting programs for related fields of study when such coordination or consolidation is deemed advisable by the national body responsible for monitoring accreditation (see III, C and V, B); and*

5. *encourage, finance, and sponsor studies that will assist in improving accreditation, including studies of the relationships of accreditation to certification, licensure, and/or registration, and the continuing needs in various fields of study for accreditation in the light of potentially changing developments in these other three selection mechanisms. (See I, A, II, B, and V, C 4.)*

IV. C

The national, independent body responsible for monitoring accreditation should be prepared to cooperate with, as well as serve in a consultative capacity to, the U.S. Commissioner of Education and other government officials, as well as to agencies, departments, and branches of the government.

In view of the continued interest of the federal government in accreditation, as conducted by independent agencies and organizations, and the numerous issues related to it, there is need for a focal point in the private

sector for accreditation. This national body could well serve this purpose. It could also serve, if and when needed, in an advisory capacity to officials of both the federal and the state governments.

V. STRUCTURE OF ACCREDITING AGENCIES

The conduct of accreditation is dependent upon the existence of agencies or organizations that assume responsibility for the establishment of essentials or standards and for the application of these standards to institutions and/or their programs of study. With respect to specialized fields of study, the number of such separate agencies has increased as more types and levels of fields of study have been subjected to accreditation. In contrast, institutional accreditation has not been conducted by a correspondingly larger number of agencies, but is generally conducted by agencies that limit their activities to institutions located in defined regions of the country. The policies of these agencies, as well as their essentials or standards, have incorporated some noticeable inconsistencies.

To rectify these conditions and to insure greater coordination and effectiveness in the accrediting process, the following principles should be implemented with respect to the agencies and organizations directly responsible for the conduct of accreditation.

V. A

The policies that apply to the conduct and operation of accreditation should be determined by national bodies which are responsive to the needs of the public and to the legitimate needs of all parties with special interests and responsibilities, and which are governed by boards of control that

1. *include individuals who represent the interests of the public, and educators and practitioners who represent the institutions and the fields and levels of study subjected to accreditation by the respective bodies, as well as others who represent the interests of the complementary professions and/or occupations; and*

2. *provide for rotation and limitation of terms of office of its members.*

Although representatives of the institutions and programs of study being subjected to accreditation, and often the members of the professions for whose fields of study accreditation is conducted are usually the most technically knowledgeable about issues related to accreditation, they do not necessarily possess all of the competencies required to reach constructively

all of the decisions involved in accreditation. Such decisions should be made with their participation supplemented by persons who have no immediate benefits to be gained by the actions of the accrediting agencies. Furthermore, persons from related fields of study and related professions should be involved to facilitate, among other things, greater cooperation and coordination in educational planning. (See I. B, II. C, and III. A.)

V. B

For purposes of coordination and efficiency, both in the conduct of accreditation and in the development and operation of educational programs preparing professional personnel, national bodies responsible for the accreditation of specialized programs of study should encompass within their jurisdictions the responsibilities for accrediting levels and fields of study that are related and complementary to each other.

Once the principle is accepted that accreditation is not the property or privilege of any one association of institutions or of any single professional organization, but is rather a social responsibility that must be assumed by organizations broadly representative of diverse interests, it is axiomatic that the agencies responsible for accreditation should include within their jurisdictions related fields and levels of study. (See III. C, and IV. B 4.)

V. C

National bodies, which are granted authority to accredit specialized programs of study, should be empowered, in the pursuance of their authority, to

1. *establish policies and criteria to which institutions and/or their programs of study will be expected to adhere in order to gain and maintain an accredited status;*

2. *conduct evaluations of and visits to institutions and/or their programs of study for purposes of accreditation upon invitation of the individual institutions;*

3. *decide and announce publicly the accredited status of institutions and/or their programs of study;*

4. *undertake and/or sponsor studies that will encourage improvements in the processes of evaluation, as well as in the educational programs within their respective areas of concern; (see II. B, and IV. B 5), and*

5. *cooperate and coordinate their activities to the maximum extent with other organizations involved with accreditation and evaluation, especially those concerned with the education of related professional personnel.*

VI. FINANCING ACCREDITING

VI. A

Accreditation should be conducted only by agencies or organizations that have assured financial resources sufficient to discharge their accrediting responsibilities effectively and properly on a continuing basis.

VI. B

The process of accreditation should be financed in a manner that ensures that the influence of those providing the funds is directed toward and limited to the objectives set forth in this statement of basic policies for accreditation.

The sources of funds for accreditation are limited to: (1) institutions and programs of study being examined for accreditation; (2) professional organizations whose members derive indirect benefits from accreditation; (3) users or beneficiaries of accreditation, such as employers of the graduates of accredited institutions and programs of study; (4) foundations; and (5) the federal and state governments. Of these, the first two will continue to be the most appropriate source of funds. Institutions and programs of study being reviewed for accreditation and reaccreditation should assume a larger proportion of direct accrediting costs than is generally the case at the present time.

SECTION THREE

Conclusions and Recommendations

The delivery of health services has already become heavily dependent on the professions allied to medicine, and it promises to become even more reliant on these professions in the years ahead. Whereas in 1950 approximately 13 percent of the personnel actively engaged in the provision of health care were physicians, by 1970 physicians accounted for only eight percent of the total active health manpower in the United States. This proportionate decrease in physicians can be attributed in large part to the striking increase in the allied medical sector which, during the same period of time, grew from a relatively modest 140,000 to 535,000—an increase of over 280 percent. The allied health professions have clearly become an increasingly important and vital segment of the health care work force and, in the light of anticipated future changes in the patterns of delivering and financing health care, it appears not only likely but inevitable that this trend will continue into the future.

Yet, at the same time that the health care system is relying ever more heavily on the allied health professions to meet its manpower needs, the effectiveness of the mechanism used to monitor and improve the quality of allied health education is, in many fields, being increasingly undermined by a host of philosophical, political, and administrative problems. Though these problems and issues are admittedly both numerous and complex, the widespread desire for their resolution is both justifiable and urgent. In order that accreditation may more adequately serve the needs of society, as well as the special legitimate interests of the health professions, it is imperative that the problems, issues, and tensions currently besetting the accreditation of the selected allied health educational programs be resolved in a cooperative, responsible, and timely manner.

ALTERNATIVES TO THE CURRENT SYSTEM

Theoretically, a number of alternatives may be advanced as possible substitutes for the present system of accrediting allied health educational programs. Among those considered by the Commission are the following:

I.

Discontinue accreditation for all allied health programs in favor of total reliance on certification and licensure.

Focusing solely on the manpower credentialing function of accreditation, this alternative suggests that professional certification and/or state licensure could alone fulfill the social need of identifying qualified personnel to staff the health care system. It is also pointed out that this type of approach would promote a more open, less exclusive, credentialing system inasmuch as all individuals, regardless of their educational and training backgrounds, would be eligible to take the examinations required to attain certification or licensure.

On the other hand, specialized accreditation serves many socially needed and desirable functions besides assisting in the credentialing of health personnel. It provides identification of programs of study for students, and for prospective donors and agencies of the federal government, as well as often stimulating faculties toward further educational improvement. If specialized accreditation were in fact discontinued, society would probably be forced to look elsewhere for a suitable means of meeting these other important social needs.

II.

Continue to vest both the primary responsibility and the final authority for the accreditation of allied health educational programs in the American Medical Association.

This proposal envisions a continuation of the status quo, accompanied by only a few, relatively minor, administrative reforms. Examples of these are: (1) the development, publication, and utilization of a given set of standard operating procedures to which all initial review bodies would be required to adhere; (2) the development and implementation of a feasible method of increasing the efficiency of accreditation by reducing unnecessary paper work and coordinating site visits; and (3) the extension of accreditation to the proprietary school sector.

This alternative assumes that the present structure of and approach to

accreditation in the allied health fields is basically sound, and that only procedural changes are needed to improve its effectiveness and enable it to resolve its substantial internal tensions and problems. However, since this proposal would continue to vest final control over accreditation of the selected health educational programs in the American Medical Association, it would likely be acceptable to few, if any, of the allied health groups currently collaborating with the AMA in the accreditation of the selected health educational programs.

III.

Vest final authority for the accreditation of allied health educational programs in a new accrediting structure while continuing to rely upon the American Medical Association for administrative support.

This alternative proposes that the accreditation of allied health educational programs continue to be lodged administratively within the American Medical Association, but stipulates that the final approval of accrediting essentials, decisions, and policies be vested in a new, more broadly representative, body that would collaborate with, but not be controlled by, the AMA.

It is believed that this arrangement would, among other things: (1) dispense with the present cumbersome system of multi-level review of accrediting decisions and policies, and (2) promote more effective and productive cooperation between physicians and allied health professionals in the accreditation of allied health educational programs by eliminating the issue of ultimate control which has been and continues to be a primary source of disagreement between the AMA and many of the allied health groups with which it collaborates.

On the other hand, while this proposal might conceivably meet the approval of at least some of the allied health groups, it would undoubtedly be resisted by others. It is also doubtful whether such a structure could be successfully integrated into the overall organizational framework of the American Medical Association. Nor does it seem fair to expect the AMA to continue to provide its current level of administrative and financial support to an organization over which it has no final control or authority.

IV.

Vest the authority and responsibility for the accreditation of allied health educational programs in an existing organization other than the American Medical Association.

This proposal envisions the transferral of final authority and administrative responsibility for accrediting allied health programs from the AMA to another existing organization. Both the Association of Schools of Allied Health Professions and the Liaison Committee on Medical Education have been proposed as possible organizations to assume this role.

While the ASAHP might appear to be a logical focus for the future accreditation of allied health programs, the Association has officially declared that it would not become directly involved in accreditation, at least in the immediate future. Moreover, while ASAHP might be an appealing organizational focus for many of the allied health groups, it probably would not be sufficiently acceptable to all of the divergent groups whose support is vital to the long-term success of any future system of accrediting allied health educational programs.

Unlike the Association of Schools of Allied Health Professions, the Liaison Committee on Medical Education has already expressed an active interest in providing an organizational focus for the future accreditation of allied health programs. A formal proposal, currently under consideration by the Liaison Committee and its sponsoring organizations, suggests that the Liaison Committee be restructured along broader representative lines to be responsible for four areas of accreditation including undergraduate medical education, graduate medical education, continuing medical education, and allied health education.

While meritorious in several respects, this proposal has not as yet gained any support from the allied health groups. Nor does it have the complete, unqualified endorsement of the medical organizations that sponsor the Liaison Committee. While the allied health professions interpret the proposal to augur increased physician dominance and control over their accrediting programs, some officials of the American Medical Association are uneasy about the proposal's implications regarding the future possibility of allied health professionals sharing in the supervision of medical education. The fact that none of the allied health groups have thus far participated in the deliberations and discussions pertaining to the Liaison Committee proposal underscores these concerns. Therefore, given the current climate of opinion, it would appear that transferance of authority and responsibility for the accreditation of allied health educational programs from the AMA to a restructured Liaison Committee would be neither desirable nor politically feasible at the present time.

V.

Vest the authority and responsibility for the accreditation of allied health educational programs in a new, independent agency.

This proposal implies that nothing short of complete separation from the American Medical Association would suffice to remedy current tensions, problems, and issues; and that, since no other organization is apparently prepared, equipped, and appropriate to undertake the responsibility for accrediting allied health educational programs, a new agency should be created to meet this social need.

Those who sponsor this proposal suggest that the new body should be broadly representative of the medical profession, the allied health professions, other complementary health professions, educators, and the public; and that it be constituted to coordinate, supervise, and exercise final authority over the accreditation of the selected health educational programs, as well as additional fields that may seek to initiate accreditation in the future.

Proponents of this alternative suggest that it would provide a broadly representative decision-making body that would not be controlled by any one profession or professional organization. As a consequence, closer and more cordial working relationships between the medical profession and the allied health groups could be developed; and improved collaboration and cooperation between the medical and allied health professions in the delivery of health care could be expected to emerge as the beneficial long-run result. Such a structure would also likely facilitate the implementation of coordinated approaches to accreditation, a development which is sorely needed in many health professional fields.

On the other hand, there are always difficulties in the creation of a new organization. Without broad-based endorsement the administrative and logistical problems in establishing a new, comprehensive allied health accrediting agency could be formidable. However, with full encouragement and support, a new organization could likely prove successful in remedying current defects in the accreditation of selected health educational programs and in improving the overall effectiveness and efficiency of accreditation in these health fields.

VI.

Allow each health profession to mount its own independent accrediting program.

Of all possible alternatives, this proposal is probably the most attractive to many of the allied health professions which, quite understandably, wish to exercise fully and autonomously the prerogative of supervising their own educational programs and controlling their own destinies. Fur-

thermore, this alternative permits the profession to exercise its full expertise, and it appears to recognize professional status.

At the same time, the implementation of this proposal would prove to be both undesirable and dysfunctional to society-at-large. Even with some type of voluntary mechanism for effecting coordination among the many diverse accrediting programs that currently exist and others that would likely emerge, it is improbable that independent accrediting efforts could cope adequately with the pressures for increased fragmentaton in the administration of accreditation, the development of educational standards, and the training of allied health personnel. Educational institutions would likely have to contend with additional site visits and unnecessary paper work. Expansion and proliferation of accrediting programs would become virtually impossible to direct or control. Though the preeminent function of accreditation is to serve the needs of society, there is little doubt that the implementation of the proposal favoring independent allied health accrediting programs would, in time, severely hinder the ability of the accrediting process optimally to serve the public welfare and operate to the long-term disadvantage of the allied health professions themselves.

VII.

Encourage regional accrediting agencies to assume the responsibility for the accreditation of allied health programs as one component of their general institutional accreditation.

It is maintained that the successful implementation of this concept would remedy many of the grievances against specialized accreditation currently cited by the educational sector since it would presumably result in fewer site visits, less paperwork, and improved coordination in the accreditation of allied health educational programs.

On the other hand, the professional associations have emphasized that regional accrediting agencies have neither the requisite expertise nor knowledge needed to evaluate the quality of specialized programs of study. Nor have the allied health professions shown any willingness to transfer their accrediting responsibilities to associations completely controlled by educational institutions that represent only a segment of the total universe of institutions offering allied health educational programs. Furthermore, there is no indication that the regional associations are prepared to assume the additional responsibility of accrediting and identifying specialized allied health educational programs.

VIII.

Support government regulation as an alternative to health educational accreditation by non-governmental agencies.

At the opposite end of the spectrum from a discontinuation of specialized accreditation is the suggestion that accreditation be replaced by government approval programs. Such approval might be conducted either by each of the fifty states or by the federal government.

Proponents of increased state governmental involvement in accreditation point out that the approval of educational programs and institutions is clearly a state responsibility and prerogative, implicitly reserved to the states by the Constitution and vouchsafed to them as a result of their heavy involvement in and financing of education. Opponents predict that only chaos would result from the existence of fifty or more different sets of approval criteria administered by fifty different state agencies and departments. It is also declared that the substitution of various state standards for current, nationally uniform, accrediting standards and evaluative norms would be a regression from the present situation, and would, in effect, undo the good that has already been accomplished by the programs and activities of national accrediting agencies.

Although state governments possess the authority and the theoretical right to sponsor health educational approval programs, they have historically lacked the means to develop, implement, and enforce uniform educational standards. Conversely, the federal government has traditionally shied away from direct involvement in higher education and the accreditation of educational programs, but has the inherent ability and wherewithal both to promulgate and to enforce national uniform standards for educational institutions and their programs of study. Nevertheless, the restraining effects of historical precedent, coupled with society's need to maintain an even and equitable balance between governmental and non-governmental forms of social control, clearly argue against the advisability of increasing the federal government's involvement in accreditation. Given the traditional opposition of the education community toward federal governmental control over postsecondary education, it would appear both politically unfeasible and unwise to make the approval of allied health educational programs a direct responsibility of the federal government.

Consonant with this philosophy and in the light of these pragmatic constraints, it is the conviction of the SASHEP Commission that the health professions must collectively devise a greatly improved means of accrediting educational programs for the allied health professions. What is being increasingly recognized is the fact that, because of the relationship between

federal funding programs and accreditation, the U. S. Commissioner of Education already possesses, in effect, the power to intervene in the affairs of the accrediting agencies, and has thus far refrained from exercising the full powers of his office in the hope that the private accrediting sector would reform itself in order to meet more adequately its substantial social obligations. If it fails to do so, more extensive governmental involvement in the accrediting process is not only likely, but virtually inevitable.

CONCLUSIONS

Each of the above alternatives to the current system of accrediting the selected health educational programs offers potential benefits and improvements as well as possible disadvantages. In assessing these alternatives, the Commission took into consideration both the problems and issues summarized in Section One of this report and the basic policies for accreditation outlined in Section Two. In addition, the Commission identified, as a further guide for its recommendations, a number of basic features which it believes must be incorporated into the structure of any future system of allied health accreditation if it is to be both conceptually and operationally sound. The Commission has concluded that:

A.

When oriented toward the needs of society, specialized accreditation of health educational programs provides a necessary, vital service to society and should therefore be continued.

Specialized accreditation, as conducted by non-governmental agencies, serves as an effective means of identifying educational programs of acceptable quality. It not only guides prospective students in their selection of schools and programs of study but also serves society by helping to identify individuals who are qualified to provide health services. However, the expansion of accreditation to additional health fields should be carefully weighed and evaluated in the light of its appropriateness for particular fields of study and types of educational programs, its likely long-term financial and administrative viability, and its need, in combination with certification and/or licensure, to identify qualified health care personnel.

B.

Fundamental changes in the organization of accreditation of allied health educational programs are needed to promote improvement in interprofessional relationships; to provide greater assurance to society

that the accrediting process will be conducted in the public interest; and to provide a more equitable balance among the many diverse parties having a legitimate interest in the accreditation of allied health educational programs.

B. 1

Physicians must be intimately involved in the process of accrediting programs of study in all of the selected allied health fields. However, the approval of standards and the accreditation of these programs of study must be subject to the final authority of a body that represents no single profession.

Because of the physician's training and expertise, and because of the unique responsibility the physician must assume in the provision of health care, physicians must continue to be active participants in the process of accrediting allied health educational programs. However, the approval of accrediting standards and the accreditation of programs of study should not be subject to the final authority of any one health professional association.

B. 2

The accreditation of allied health educational programs must promote increased collaboration, cooperation, and coordination among the health professions.

Because the effective and efficient delivery of health care is becoming increasingly dependent upon close interaction and cooperation among members of many diverse health professions, it is essential that the future accreditation of health educational programs be structured and conducted to encourage these mutually supportive relationships. While the restructuring of accreditation in the selected health fields must give ample attention to the legitimate special interests and different types of expertise possessed by various health professionals, it must at the same time adequately recognize that many features and characteristics are held in common by the educational programs preparing these individuals for health service roles.

B. 3

The accreditation of allied health educational programs must be reorganized to improve both its efficiency and its effectiveness.

The current manner of accrediting the selected allied health educational programs is ponderous and expensive. Institutions offering allied health programs are justifiably concerned about the duplicative paperwork, the

numerous site visits, and the unnecessary expenditures of faculty time and institutional resources necessitated by the lack of coordination among allied health accrediting programs. At the same time, those responsible for allied health accreditation question the ability of the accrediting agencies adequately to meet their expanding responsibilities in the light of rapidly growing demands on their time and resources and fast-rising accrediting costs. It is, therefore, imperative that the current approach to accrediting allied health educational programs be revised to place accreditation on a firmer financial base, to increase its administrative efficiency and cost effectiveness, and to improve the quality of the services it offers to the educational sector.

B. 4

The structure for accrediting allied health educational programs must give adequate attention to the need for appropriate flexibility and innovation, including specific provision for the incorporation of other health professions within the system.

Patterns of health care delivery, perceived health manpower needs, and the education of personnel for health service roles are in a state of constant, dynamic change. Therefore, any future system of accrediting health educational programs must be structured to enable it to adapt with sufficient flexibility to relevant changes and developments in the health care system as well as to additional legitimate social demands that in the future may be placed upon it.

C.

Policies for all accreditation of postsecondary institutions and programs of study should be established by a national monitoring body, and the accreditation of programs of study for all allied health occupations should conform to the policies adopted and established by this body.

Concurrent with the conduct of SASHEP, constructive steps are being taken under the leadership of the Federation of Regional Accrediting Commissions of Higher Education and the National Commission on Accrediting to create a national monitoring body that is likely to conform in most respects to the recommendations for such a body presented in Section Two, Part IV, of this report. Assuming that a national monitoring body with comprehensive responsibilities to oversee and supervise all institutional and specialized accreditation at the postsecondary level will indeed be established, and that policies adopted by this body will be consistent with

the best interests of society, it is axiomatic that the policies and procedures adopted and implemented by the agency responsible for allied health accreditation should adhere to those enunciated by the national monitoring body. In the interim, these policies and procedures should conform to criteria of the National Commission on Accrediting which currently serves a coordinating and monitoring function for specialized accreditation.

RECOMMENDATIONS

In response to the problems and issues identified in Section One, in agreement with the basic policies for accreditation presented in Section Two, and in conformity with the above conclusions regarding the future accreditation of allied health educational programs, the Commission presents the following recommendations:

1.

The Association of Schools of Allied Health Professions, the Council on Medical Education of the American Medical Association, and the National Commission on Accrediting should jointly sponsor one or more meetings for representatives of all organizations directly concerned with the accreditation of allied health educational programs for the purpose of discussing and implementing the concepts and recommendations contained in this report.

The successful implementation of the concepts and recommendations contained in this report will depend to a large extent upon adequate follow-up and communication with the numerous agencies and associations directly involved in the accreditation of allied health educational programs. Because the three organizations that have served as the co-sponsors of the Study of Accreditation of Selected Health Educational Programs have an immediate interest in the results of this study, it is anticipated that they will wish to encourage widespread understanding and acceptance of the concepts presented in the Commission Report. The Commission, therefore, recommends that the Association of Schools of Allied Health Professions, the Council on Medical Education of the American Medical Association, and the National Commission on Accrediting co-sponsor one or more meetings, commencing in the fall of 1972, for representatives of the organizations having a direct interest in the accreditation of allied health educational programs in order that they may discuss the following recommendations and plan the steps to be taken toward the implementation of the principles contained in the Commission Report.

2. A

An independent, broadly-representative organization, the Council on Accreditation for Allied Health Education, should be established to

a. provide a forum for the discussion of issues, problems, trends, and developments pertinent to allied health education, including its relationship to manpower needs and services;

b. serve as a forum for cooperative curricular analysis of both traditional and non-traditional programs of study;

c. sponsor, coordinate, and supervise the accreditation of the selected allied health educational programs;

d. approve standards for the accreditation of the selected allied health educational programs;

e. establish uniform policies and procedures for the accreditation of the selected allied health educational programs;

f. seek recognition from the national monitoring body for new accrediting programs in additional fields of study when such programs are initiated (see Section Two, Part IV);

g. sponsor and cooperate in the conduct of research relating to the evaluation of allied health educational programs, including the validation of accrediting standards and procedures; and

h. provide effective liaison with certifying and licensing agencies and sponsor and cooperate in studies concerned with the operations and relationships of accreditation to certification and licensure.

Because accreditation is so intimately related to curricular development and planning, the system of accrediting allied health programs should provide, both organizationally and operationally, for concurrent consideration of other issues and developments in health professional education. In addition, because of its manpower credentialing function, the accrediting system should be linked to developments in certification and licensure. In accord with these needs, the Commission believes that performance of the functions outlined above provides the greatest potential for allied health accreditation to serve the needs of society in the best possible manner.

2. B

The Council on Accreditation for Allied Health Education should be comprised of

a. practicing *physicians* appointed by the American Medical Association, the American Board of Medical Specialties, and the Council of Medical Specialty Societies;

b. practicing *allied health professionals* appointed by national allied health professional organizations;

c. *educators* appointed by the Association of Schools of Allied Health Professions and the Association of American Medical Colleges;

d. *representatives of institutional employers* appointed by the American Hospital Association and the National Health Council;

e. *public representatives* appointed by the Education Commission of the States;

f. *other health professionals* appointed by complementary national health professional associations; and

g. *representatives of the federal government* designated by the Secretary of Health, Education, and Welfare.

As the policy-making body for allied health accreditation, the Council on Accreditation for Allied Health Education should be broadly representative of the diverse groups having a legitimate interest in the accreditation of allied health programs. Because accreditation is so heavily dependent on the constructive participation of individuals representing a wide variety of backgrounds, competencies, and types of expertise, the Commission believes it is essential that the proposed Council encourage the broad participation of a wide diversity of individuals, and be capable of promoting effective collaboration and cooperation among them.

Voting Membership

To these ends and in accord with the scope of functions outlined in Recommendation 2 A, it is proposed that the Council's voting membership be composed of: (a) physicians appointed by the American Medical Association, the American Board of Medical Specialties, and the Council of Medical Specialty Societies; (b) allied health professionals appointed by national allied health professional associations that sponsor accrediting programs recognized by a national monitoring body on condition that these accrediting programs are incorporated within the structure of the Council; (c) educators appointed by the Association of Schools of Allied Health Professions and the Association of American Medical Colleges; (d) participants appointed by the American Hospital Association and the National Health Council; and (e) participants appointed by the Education Commission of the States. In regard to the participation of educators (c), it is suggested that the appointments provide for a sufficient diversity of educational responsibilities in a variety of institutional settings, including universities, four-year and two-year colleges, technical and vocational institutes, and hospitals. Eligibility for appointment should not be limited to individuals from schools holding membership in the appointing organizations.

Associate Non-Voting Membership

To provide additional expertise as well as the necessary flexibility to incorporate new accrediting programs into the accrediting structure, it is proposed that associate, non-voting membership be extended to participants appointed by complementary national health professional associations, including those that represent the dental and nursing professions; national medical organizations other than the American Medical Association, including the National Medical Association and the American Osteopathic Association; and national allied health professional organizations, including those associations that do not sponsor recognized accrediting programs but wish to participate in the curricular development, research, and credentialing-related activities of the Council. In addition, representatives of the federal government involved in education and health affairs should be invited to attend Council meetings as observors.

2. C

The program responsibilities of the Council on Accreditation for Allied Health Education should be discharged through a series of standing committees that include, but are not limited to, the following:

Accrediting Committee

It is proposed that, subject to the right of appeal to the Council, the accrediting committee be empowered to take final action on the accreditation of individual educational programs. It should also be responsible for proposing revisions in accrediting policies and procedures for consideration and adoption by the Council, as well as for appointing review subcommittees to conduct the evaluation of educational programs.

To ensure a sufficiently broad base of expertise and to assure that no one group is dominant in the decision-making processes, the accrediting committee should be composed of allied health professionals, physicians, educators, and public representatives. Members of the accrediting committee should be elected by the Council from names submitted by the Council participants possessing voting privileges; eligibility to serve on the accrediting committee should not be limited to members of the Council.

Members of the review subcommittees should be health professionals selected by the accrediting committee from individuals nominated by the organizations participating as voting members of the Council. Review subcommittees should be structured along multidisciplinary lines to encourage clustering of closely related occupational specialties, as well as to encourage improved coordination in the accreditation of allied health educational programs.

Essentials and Educational Standards Committee

A broadly representative committee on essentials and educational standards should be established to encourage a coordinated approach to comprehensive curricular development among the allied health occupations. Because of the interdependence of the allied health professions in both the educational and service settings, it is imperative that educational standards for any given health profession be considered in the context of those for other related health professions. Thus, while individual health professional organizations will likely continue to take the initiative in developing, drafting, and recommending essentials for the accreditation of allied health educational programs, the committee on essentials and educational standards should be responsible for studying, analyzing, and reviewing all essentials in the context of those for other related professions.

Like the accrediting committee, the essentials and educational standards committee should be comprised of allied health professionals, physicians, educators, and public representatives. Members of the committee should be elected by the Council from names submitted by the voting Council participants, and membership should not be limited to those serving on the Council.

Curricular Development Committee

Effective and frequent communication between the accrediting agency and the educational institutions offering allied health programs is necessary if accreditation is to provide maximum assistance to the institutions. Since one of the primary functions of accreditation is to improve educational offerings, it is appropriate that accreditation give as much weight and attention to its role as advisor as to that of judge. Therefore, a curricular development committee should be established to provide a forum from the exchange of ideas and to explore means of providing advisory services to allied health educational programs.

This committee should also be comprised of individuals elected by the Council from names submitted by the Council participants possessing voting privileges, and membership should not be limited to those serving on the Council.

Research Committee

It is proposed that a research committee be established to initiate, develop, and sponsor appropriate research projects relating to the evaluation of allied health educational programs, including the validation of accrediting standards and procedures. By providing a central organizational focus

for research related to allied health accreditation, it is anticipated that the long overdue objective evaluation of accrediting standards and procedures will attract the increased attention, visibility, and financing needed to encourage sound research activities in these areas. The research committee should be comprised of individuals elected by the Council from names submitted by the Council's voting and non-voting participants.

Liaison Committee on Certification and Licensure

Because of the close linkages among accreditation, certification, and licensure as manpower credentialing mechanisms, it is proposed that a liaison committee on certification and licensure be established to maintain effective ongoing liaison with allied health professional certifying and licensing agencies as well as with those agencies engaged in the development and implementation of equivalency and proficiency examinations for selected categories of health care personnel. In addition, the committee, on behalf of the Council, should initiate, develop, sponsor, and cooperate in studies concerned with the operations and relationships of accreditation to certification and licensure. As with the research committee, the liaison committee on certification and licensure should be comprised of individuals elected by the Council from names submitted by both the voting and non-voting members of the Council.

2. D

The operational responsibilities of the Council on Accreditation for Allied Health Education should be discharged through a series of standing committees that include, but are not limited to, the following:

Nominating Committee

Membership Committtee

Finance Committee

It is suggested that the Council establish a nominating committee to nominate individuals to serve as officers of the Council and as members of the Council's committees; a membership committee to recommend organizations eligible to appoint individuals to serve on the Council; and a finance committee to recommend annual budgets, and revisions in financing procedures and policies to the Council. Both full and associate members should be eligible to serve on the operating committees subject to election by the Council for limited terms of service.

2. E

Financial support for the Council on Accreditation for Allied Health Education should be borne primarily by the health professional associations and educational programs seeking to attain or maintain accredited status.

Direct accrediting costs should be borne primarily, though not totally, by the educational institutions and programs participating in the Council's accrediting activities through the payment of fees and the assumption of actual site visit costs.

Financial support for the other related programs and activities of the Council should be provided by the organizations that appoint participants to serve on the Council. In addition, it is anticipated that travel costs to Council meetings will be assumed by the participants' appointing organizations and that research funds will be solicited from foundation and government sources. It is further expected that all revenues will be deposited in the central account of the Council, which, through its finance committee, will bear the responsibility for adequately funding the programs carried out under its authority and supervision.

3.

The basic approach to the accreditation of allied health educational programs must be reoriented. Improvements should include, but not be limited to, the following: (a) providing for multidisciplinary site visit teams, (b) vesting additional responsibility for assuring the quality of clinical preparation in educational institutions, and (c) requiring more rigorous procedures for the accreditation of independent hospital and laboratory training programs.

To be fully effective, accreditation must be compatible with institutional arrangements for providing allied health education and cognizant of the diverse needs of the several different types of institutions offering allied health educational programs. In accord with these goals and in light of the urgent needs to simplify the accrediting process, to encourage increased interaction and cooperation among the health professionals involved in accrediting allied health educational programs, and to reduce costs, it is recommended that current accrediting criteria and procedures be redesigned to encourage the utilization of properly structured multidisciplinary site visit teams to institutions seeking accreditation or reaccreditation for a number of allied health educational programs.

It is further recommended that educational institutions maintaining affiliate relationships with clinical training facilities be required to assume

the preeminent responsibility for assuring the quality of the clinical, as well as the didactic, portion of their educational programs. Accredited status should, therefore, be extended only to sponsoring educational institutions, which, in turn, should be expected to monitor the training offered in clinical facilities with which they are affiliated. It is anticipated that the implementation of this policy would not only reduce the current financial and logistical problems inherent in the present system of accrediting allied health educational programs, but would also promote closer interaction and articulation between the didactic and clinical components of allied health training programs.

The procedures for the accreditation of independent hospital and laboratory programs must, however, take into account both the absence of any alternative formal mechanism for monitoring program quality and the limited educational structure of such programs. To provide reasonable assurance about the quality of independent, hospital- and laboratory-based training programs, it is essential that more frequent evaluation visits and closer monitoring procedures for these programs be established and required.

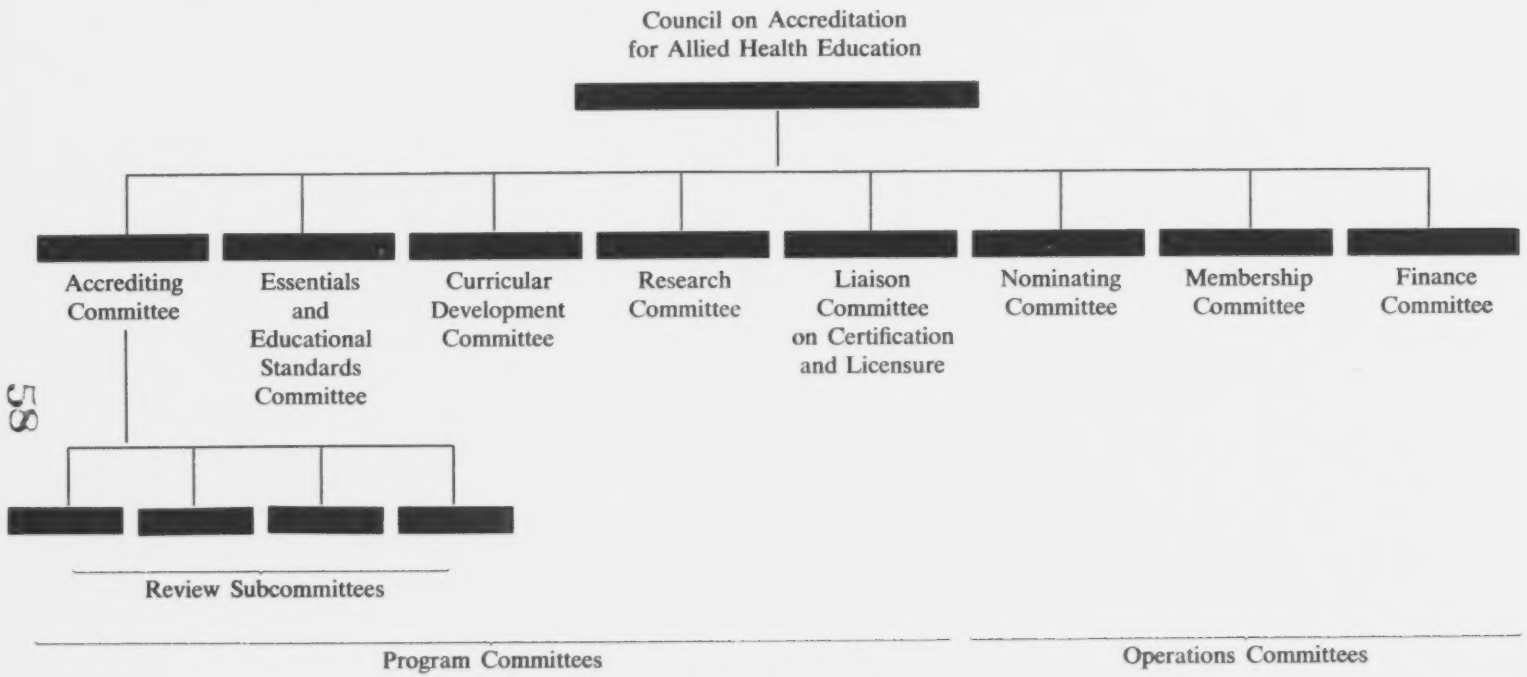
CONCLUDING OBSERVATIONS

The economic, political, social, and technological pressures that are forcing changes in all aspects of society are also requiring that the structure and operations of accreditation be revised. Cognizant of the need for change the American Medical Association initiated this Study of Accreditation of Selected Health Educational Programs, and with the Association of Schools of Allied Health Professions and the National Commission on Accrediting, has co-sponsored SASHEP.

In this report the SASHEP Study Commission has presented specific recommendations for the creation of a new organization to be responsible for the accreditation of the selected health educational programs that are the primary focus of the study. The creation of this new organization would be a constructive response to the pressures facing accreditation. However, the creation of such an organization would not alone be adequate for the needs of the times.

Of even more importance is the need for recognition and acceptance of the concepts contained in this report on the part of all agencies and organizations directly concerned with the accreditation of the selected health educational fields. To attain this objective the Commission believes that the three co-sponsors of SASHEP must immediately initiate steps toward joint consideration and implementation of the concepts presented in this report.

APPENDIX A


Council on Accreditation
for Allied Health Education
Accrediting Committee
Essentials and Educational Standards Committee
Curricular Development Committee
Research Committee
Liaison Committee on Certification and Licensure
Nominating Committee
Membership Committee
Finance Committee
Review Subcommittees
Program Committees
Operations Committees

APPENDIX B

The 15 Selected Health Educational Programs Serving as the Focus of SASHEP

Allied Health Profession	*Organizations collaborating with AMA in Accreditation*	*Review Bodies of Collaborating Organizations*
Certified Laboratory Assistant Cytotechnologist Histologic Technician Medical Technologist	American Society for Medical Technology American Society of Clinical Pathologists	Board of Schools— Committees on: Certified Laboratory Assistant Cytotechnologist Histologic Technician Board of Schools
Inhalation Therapy Technician	American Association for Inhalation Therapy American College of Chest Physicians American Society of Anesthesiologists	Joint Review Committee for Inhalation Therapy Education
Medical Assistant	American Association of Medical Assistants	Curriculum Review Committee
Medical Record Librarian Medical Record Technician	American Medical Record Association	Education and Registration Committee

Allied Health Profession	*Organizations collaborating with AMA in Accreditation*	*Review Bodies of Collaborating Organizations*
Nuclear Medicine Technician Nuclear Medicine Technologist	American College of Radiology American Society for Medical Technology American Society of Clinical Pathologists American Society of Radiologic Technologists Society of Nuclear Medical Technologists Society of Nuclear Medicine	Joint Review Committee on Educational Programs in Nuclear Medicine Technology
Occupational Therapist	American Occupational Therapy Association	Accreditation Committee
Orthopaedic Assistant	American Academy of Orthopaedic Surgeons	Subcommittee on the Orthopaedic Assistant
Physical Therapist	American Physical Therapy Association	Committee on Basic Education
Radiation Therapy Technologist Radiologic Technologist	American College of Radiology American Society of Radiologic Technologists	Joint Review Committee on Education in Radiologic Technology

APPENDIX C

List of Organizations that Provided Questionnaire Information to SASHEP

Academy of Certified Social Workers, National Association of Social Workers
Accrediting Bureau of Medical Laboratory Schools
Accrediting Commission, International Society of Clinical Laboratory Technologists
Accrediting Commission on Graduate Education for Hospital Administration
American Academy of Pediatrics
American Association for Inhalation Therapy
American Association of Blood Banks
American Association of Medical Assistants
American Association of Nurse Anesthetists
American Board for Certification in Orthotics and Prosthetics
American Board of Clinical Chemistry
American Board of Health Physics
American Board of Medical Microbiology
American Board of Professional Psychology
American Board of Registration of Electroencephalographic Technologists
American Chemical Society
American College of Chest Physicians
American College of Nurse Midwives
American College of Radiology
American Corrective Therapy Association
American Council on Pharmaceutical Education
American Dental Association
American Dental Assistants' Association
American Dietetic Association
American Medical Association
American Medical Record Association

American Medical Technologists
American Occupational Therapy Association
American Optometric Association
American Osteopathic Association
American Physical Therapy Association
American Podiatry Association
American Psychological Association
American Public Health Association
American Registry of Inhalation Therapists
American Registry of Radiologic Technologists
American Society for Medical Technology
American Society of Anesthesiologists
American Society of Clinical Pathologists
American Society of Radiologic Technologists
American Speech and Hearing Association
American Veterinary Medical Association
Association of American Medical Colleges
Association of Operating Room Technicians
Board of Schools, American Society of Clinical Pathologists
Council on Social Work Education
Joint Commission on Accreditation of Hospitals
Joint Review Committee for Inhalation Therapy Education
Joint Review Committee on Education in Radiologic Technology
Joint Review Committee on Educational Programs in Nuclear Medicine Technology
Liaison Committee on Medical Education
Medical Library Association
National Association for Music Therapy
National Board for Certification in Dental Laboratory Technology
National Association for Practical Nurse Education and Service
National Association of Physical Therapists
National Association of Trade and Technical Schools
National League for Nursing
National Registry in Clinical Chemistry
National Registry of Microbiologists
Registry of Medical Technologists, American Society of Clinical Pathologists
Society of Nuclear Medical Technologists
Society of Nuclear Medicine